Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCUS P HAYES
PO BOX 198
BARKER, TX 77413-0198

Respondent Name
NORTHSIDE ISD

Carrier's Austin Representative Box
Box Number 16

MFDR Tracking Number
M4-13-0376-01

MFDR Date Received

October 05, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… Regarding denial code "165", the referral from the current treating doctor, Selena Gary, DC, was provided to the IC with the request for reconsideration, therefore, denial code 165 is invalid. Regarding denial code "18", the claimant in this case was placed at MMI by her previous treating doctor. The claimant underwent additional treatment with her new treating doctor, Selena Gary, DC, and Dr. Gray did not believe the patient was at MMI per the previous TD's certification. Therefore, Dr. Gray, referred the claimant for evaluation to reassess if MMI was attained, specifically if the date was different than the previous TD's certification, and if so, what the percent of impairment."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The first certification of MMI and IR was rendered by the treating doctor. There has not been a Designated Doctor certification. Therefore, Texas Labor Code Section 408.0041 (1-2) does not apply. The carrier stands by the original determination."

Response Submitted by: Sedgwick

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2012	CPT Code 99456-WP	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services

on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 05, 2012

   - 165 – Payment denied/reduced for absence of, or exceeded referral
   - 18 – Duplicate claim/service

   Explanation of benefits dated September 25, 2012

   - 193 – Original payment decision is being maintained. This claim was processed properly the first time

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-WP in the amount of $500.00 for one unit for a Maximum Medical Improvement (MMI) and Impairment Rating (IR) examination.

   Review of the submitted documentation supports that a Maximum Medical Improvement (MMI) and Impairment Rating examination was requested to one body area being performed using Diagnosis Related Estimate (DRE) method.

   Per Administrative Code (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350, (4) The following applies for billing and reimbursement of an IR evaluation, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (i) Musculoskeletal body areas are defined as follows, (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet), (ii) The MAR for musculoskeletal body areas shall be as follows, (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used and (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

   Therefore, CPT Code 99456-WP is supported. Total reimbursement is $500.00

2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $500.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/23/13 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.